Capital BlueCross
AMBULATORY SURGICAL FACILITY SURVEY

Provider Name: ______________________________
CBC #: ______________ **Medicare #:** ______________ **Medicaid #:** ______________
Accrediting Organization: ______________ **Date of most recent accrediting survey:** __________
Person completing survey: ______________ **Phone:** __________ **Date:** __________
Contact person (if different than above): ______________________ **Phone:** __________

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

Days & Hours of operation:
Handicap access ☐ Yes ☐No
Pediatric services provided ☐ Yes ☐No
Ages:
Number of operating rooms:
Special procedure rooms *(list types below)* ☐ Yes ☐No

Minimum number of nurses present during total hours of facility operation:
Physician present and available during total hours of facility operation ☐ Yes ☐No
Written compliance program ☐ Yes ☐No
Compliance program officer ☐ Yes ☐No
Internal compliance audits ☐ Yes ☐No
Review of the Medicare/Medicaid sanction report ☐ Yes ☐No
Frequency of review:
Written policy on patient confidentiality ☐ Yes ☐No
Written policy on medical record confidentiality ☐ Yes ☐No
Written policy for release of medical records ☐ Yes ☐No
Written policy for maintenance/retention of medical records ☐ Yes ☐No
Written patient medical emergency plan ☐ Yes ☐No
Emergency crash carts/supplies available ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Written policy for checking:
Emergency crash cart/supplies ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Policy includes frequency of checks ☐ Yes ☐No
Written transfer agreement with acute care ☐ Yes ☐No
If **yes**, list facilities:
Agreement with emergency transport service ☐ Yes ☐No
Reliance on 911 system ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities
Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes utilization review ☐ Yes ☐No
Development of improvement activities based on identified issues ☐ Yes ☐No
Performance Improvement Committee ☐ Yes ☐No
Frequency of meetings:
Quality Reports forwarded to the Board of Directors ☐ Yes ☐No
List two Current Quality Studies:
1.
2.
Written infection control policies ☐ Yes ☐No

Patient Satisfaction
Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: ______ %
Issues identified:
1.
2.
Results forwarded to PI committee ☐ Yes ☐No
Written patient/family complaint process ☐ Yes ☐No

Clinical Management
Written policy on addressing advance directives ☐ Yes ☐No
Pre-admission patient contact ☐ Yes ☐No
Written protocol for pre-op testing ☐ Yes ☐No
Written guidelines for post-anesthesia observation ☐ Yes ☐No
Maximum observation time before transfer to an acute care facility:
Follow-up call post-discharge ☐ Yes ☐No

Patient Education
Pre & Post Op Patient/Family education ☐ Yes ☐No
Documented in clinical record ☐ Yes ☐No

Provider Name:

Services for hearing impaired ☐ Yes ☐No
Services for speech impaired ☐ Yes ☐No
Services for visually impaired ☐ Yes ☐No
Bilingual services ☐ Yes ☐No
Bilingual patient education materials ☐ Yes ☐No
Languages offered:

Data Collection

Prolonged recovery time ☐ Yes ☐No
Transfers to hospital ☐ Yes ☐No
Surgical complications ☐ Yes ☐No
Surgical delays ☐ Yes ☐No
List other data:

CLINICAL STAFF

Written policy for clinical competency evaluation ☐ Yes ☐No
Evaluated during probationary period ☐ Yes ☐No
Evaluated annually ☐ Yes ☐No
Written policy for verification of the following for all clinical staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Number of mandatory educational programs staff is required to attend annually:
Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No
Medical Director ☐ Yes ☐No
Specialty:
Board certified ☐ Yes ☐No
Written policy for credentialing of physicians ☐ Yes ☐No
Written policy for recredentialing of:

- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Frequency:

Medical Staff

________ Number of Anesthesiologists
________% Board Certified in Anesthesiology
________ Number of Surgeons
________% Board Certified in Surgery

If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Nursing Staff

Number of RNs
Number of Certified Perioperative Nurses
Number of LPNs
Number of NAs
Number of CRNAs
Number of Certified OR Technicians

Written policy defining staff requiring CPR certification ☐ Yes ☐No
________% Clinical staff CPR certified
________% Clinical staff ACLS certified
# of CPR certified staff available when patients are present: ________
RN/Patient ratio in recovery room ________

SERVICES

Please indicate which surgical services are provided

Cardiovascular ☐ Yes ☐No
ENT ☐ Yes ☐No
Gastroenterology ☐ Yes ☐No
General ☐ Yes ☐No
Gynecologic ☐ Yes ☐No
Laparoscopic ☐ Yes ☐No
Laser ☐ Yes ☐No
Ophthalmologic ☐ Yes ☐No
Oral ☐ Yes ☐No
Orthopedic ☐ Yes ☐No
Pain Management Procedures ☐ Yes ☐No
Plastic/Reconstructive ☐ Yes ☐No
Stereotactic breast biopsy ☐ Yes ☐No
Urology ☐ Yes ☐No
Other (please list):

Laboratory

Access ☐ Yes ☐No
Facilities used:

Radiology

Access ☐ Yes ☐No
Facilities used:
Fluroscopy ☐ Yes ☐No

FACILITIES AND EQUIPMENT

Bioengineering specialist ☐ Yes ☐No
If no, person responsible for maintenance of biomedical equipment ☐ Yes ☐No

Provider Name:

Written policy for handling biohazardous materials ☐ Yes ☐No
Written preventive maintenance plan ☐ Yes ☐No
Written plan for equipment failure ☐ Yes ☐No
Written emergency preparedness plan ☐ Yes ☐No
Plan includes:

- Fire ☐ Yes ☐No
- Loss of utilities ☐ Yes ☐No
- Inclement weather ☐ Yes ☐No

Written policy for fire & disaster drills ☐ Yes ☐No
Results of drills documented ☐ Yes ☐No

As a reminder, please be sure to include:

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***

COMMENTS

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:____

Parent:____

Affiliation:____

Affiliation:____

Number of Years in business:__________________________

Type of Control

☐ **Voluntary Nonprofit**

☐ **Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)

- ☐ Individual ________________________________
- ☐ Partnership________________________________
- ☐ Corporation________________________________
- ☐ Other_____________________________________

☐ **Government**

- ☐ Federal
- ☐ State
- ☐ County
- ☐ Other, explain:______________________________

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

- ☐ Yes, explain:________________________________
- ☐ No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

- ☐ Yes
- ☐ No

If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: ____

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Provider Name:

Adams ☐ ______________________________
Berks ☐ ______________________________
Centre ☐ ______________________________
Columbia ☐ ______________________________
Cumberland ☐ ______________________________
Dauphin ☐ ______________________________
Franklin ☐ ______________________________
Fulton ☐ ______________________________
Juniata ☐ ______________________________
Lancaster ☐ ______________________________
Lebanon ☐ ______________________________
Lehigh ☐ ______________________________
Mifflin ☐ ______________________________
Montour ☐ ______________________________
Northampton ☐ ______________________________
Northumberland ☐ ______________________________
Perry ☐ ______________________________
Schuylkill ☐ ______________________________
Snyder ☐ ______________________________
Union ☐ ______________________________
York ☐ ______________________________

Other ☐ ______________________________
____
____
____
____